Berkshire Life Insurance Company of America
700 South Street
Pittsfield, Massachusetts 01201
Berkshire Life Insurance Company of America is a subsidiary of and an administrator for The Guardian Life Insurance Company of America, New York, NY

AUTHORIZATION TO OBTAIN INFORMATION

For Assistance, Call Toll Free 1-888-275-7473

Name of Insured

Policy Number(s)

Address of Insured

Date of Birth

Permission to Obtain and Disclose Information

I AUTHORIZE any physician, medical or mental health professional, medical practitioner, hospital, clinic, healthcare or other medical or medically related facility, healthcare provider, pharmacy, pharmacy benefit manager, therapist, benefit plan administrator, business associate, insurer or reinsurer, consumer reporting agency subject to the Fair Credit Reporting Act, insurance support organization, insurance agent, employer, financial institution, Governmental Agency including The Social Security Administration, The Veteran's Administration or any other organization or person having any knowledge of me or my health to give Berkshire Life Insurance Company of America ("Berkshire") or its employees and agents, or its authorized representatives any information in its possession about me. This information includes, but is not limited to, medical information as to cause, treatment, diagnoses, prognoses, consultations, examinations, tests or prescriptions with respect to my physical or mental condition or treatment of me. This may include (but is not limited to) HIV infection, any disorder of the immune system, including acquired immune deficiency syndrome (AIDS), mental illness or use of alcohol or drugs. This information also includes non-medical information concerning me, my occupation, employment history, driving history, earnings or finances or information otherwise needed to determine policy claim benefits that may be due me.

I UNDERSTAND that this authorization is part of the policy's Proof of Loss requirement and if I revoke or fail to sign this authorization or alter its content in any way, it may affect the handling of my claim, including the denial of benefits under my policy. Any information obtained will not be released by Berkshire Life Insurance Company of America to any person or organization except to: affiliates, reinsuring companies, other persons (including my attending medical provider) or insurance support organizations performing business or legal services in connection with my claim or application for insurance or as may be otherwise lawfully required or as I may further authorize. Information disclosed pursuant to this authorization is no longer covered by federal privacy rules and may be redisclosed pursuant to this authorization or as otherwise permitted or required by law.

I understand that I have the right to revoke this authorization in writing at any time by sending a written request for revocation to 700 South Street, Pittsfield, MA 01201. I understand that a revocation is not effective to the extent that Berkshire has already relied on this authorization, or to the extent that the company has a legal right to contest a claim under an insurance policy or to contest the policy itself.

I UNDERSTAND some states require that I be informed that: "Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, may be committing a fraudulent insurance act, which is a crime and subject to criminal prosecution, substantial civil penalty and the stated value of the claim for each violation."

I AGREE the information obtained with this authorization may be used by Berkshire Life Insurance Company of America to determine eligibility for benefits under my policy. A photocopy of this form is as valid as the original, and I may request one. This form is valid up to 24 months from the date shown below (12 months in Kansas).

I, Scott Chapman, Date of Birth August 14, 1965, Social Security Number _____, **AUTHORIZE** the Social Security Administration to release information or records about me to Berkshire or its authorized representative. This information is to be released in order to properly adjudicate my claim or continue my eligibility for benefits. Please release detailed earnings for up to the last ten years and/or summary record of total earnings and/or information from master benefit records regarding award, denial or continuing benefits.

I declare that all answers, statements and information made or given by me, or at my direction, in connection with this claim are and have been complete and true.

Authorizing Signature

Date

Relationship or authority, if other than Insured

Berkshire Life Insurance Company of America
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DISABILITY CLAIMANT'S STATEMENT AND DESCRIPTION OF OCCUPATION

For Assistance, Call Toll Free 1-888-275-7473

Please answer **every** question and complete the authorization. An incomplete form or authorization could delay the processing of your claim. If more space is needed, please provide applicable information on additional pages.

Name of Insured | Date of Birth | ☐ Single ☐ Married | Height | Weight

Present Residence Address: No. and Street | Mailing Address (if different)

City | State | Zip Code | Social Security #

(Home) | (Work) | (Cell) | (Fax)
Telephone #s

E-mail Address

1. **Nature of Disability** (Complete A or B)

   A. ☐ **Injury** – Description of Accident and Resulting Injuries _____

   Place Injury Occurred (Name and Address) _____

   Date and Time of Injury _____

   Was a report filed? ☐ Yes ☐ No If yes, please provide copy of report.

   Name(s) of Witness(es) _____

   Any other injury(ies) in past five (5) years? ☐ Yes ☐ No If "Yes," please provide date(s) and nature of injury(ies).

   B. ☐ **Sickness** - Nature of Sickness _____

   Date of First Symptoms _____ Have you ever had the same or similar sickness? ☐ Yes ☐ No

   Any other sickness(s) in past five (5) years? ☐ Yes ☐ No If yes, please provide date(s) and nature of sickness(s).

2. **Period of Disability**

   A. I have not worked at all in my occupation (or occupations) due to disability from _____ (date) to _____ (date)

   B. I have worked in a reduced capacity in my occupation (or occupations) due to disability from _____ to _____ (date) (date)

   C. Did your attending physician advise you to stop work altogether, or work in a reduced capacity for the dates indicated? ☐ Yes ☐ No

3. **Medical**

   A. Date of first treatment by a physician (or other medical care provider) for this injury or sickness _____

   B. Please provide the name(s) and address(es) of your primary care provider(s) for the past five (5) years:

C. List the name, address, telephone number, and dates of treatment of all treating providers for this injury or sickness:

Name	Address	Telephone #	Dates of Treatment

D. List the name, address, telephone number, and dates of treatment of all hospitals and/or facilities where you have received treatment for this injury or sickness:

Name	Address	Telephone #	Dates of Treatment

E. List all of your prescribed medications and dosages and the name, address, and telephone number of all pharmacies you use:

Medications and Dosages	Name of Pharmacy	Address	Telephone #

4. **Individual Disability Income Policy Premium Payments:**

Berkshire Life Insurance Company of America assumes no liability for errors in reporting of tax liability and reliance thereon for tax withholding. Berkshire Life Insurance Company of America offers no tax advice. Please consult your tax advisors if questions arise.

Notice: Pursuant to Federal Law and IRS Regulations, your benefits may be subject to mandatory Social Security and Medicare Tax withholding (FICA). Benefits paid, proportionate to any premium paid with employer or pre-tax dollars, may have FICA withheld. Any taxes withheld will be reported to your employer monthly and at year-end for inclusion with your Employer issued W-2 Form. Berkshire Life Insurance Company of America will not issue you a W-2.

Please check the situations below that describe who paid what percentage of premium over the past year on your individual disability income policy. Please provide applicable information on an additional page if you have more than five policies.

		Check all boxes that apply	Please provide policy numbers and indicate % of premium paid. Policy #	Policy #	Policy #	Policy #	Policy #
Not Subject to FICA withholding	A ☐	Yourself with after-tax dollars					
	B ☐	Your Sole Proprietorship					
	C ☐	Your Partnership					
	D ☐	Your S Corporation and you are a more than 2% owner					
	E ☐	Your C Corporation but the value of the premium payments has been included in your gross salary					
Subject to FICA Withholding	F ☐	Yourself with pre-tax dollars					
	G ☐	Your employer and you have no ownership interest in that employer					
	H ☐	Your S Corporation and you have a 2% or less ownership interest					
	I ☐	Your C Corporation					

Berkshire Life Insurance Company of America will rely on the information above in determining whether or not FICA will be withheld.

Sections **A through E:** your benefits, proportionate to the percentage of premium paid, **are not** subject to FICA withholding.

Sections **F through I:** your benefits, proportionate to the percentage of premium paid, **are** subject to FICA withholding.

Please attach a copy of your last pay stub for the period just before disability onset.

5. **Other Benefits**

A. List all other companies with which you are insured for Disability (Health) and/or Medical Benefits (if "none," so state)

Company	Policy No.	Type of Coverage	Group/ Individual	Effective Date of Coverage	Amount of Benefits (State Weekly or Monthly)

B. List all other benefits for which you are eligible, have applied, or you are now receiving:

	Applied Yes	Applied No	Receiving Yes	Receiving No	Eligible Yes	Eligible No	Date Applied For	Amount Received Weekly	Amount Received Monthly	Effective Date
(1) Social Security (Self)	☐	☐	☐	☐	☐	☐				
If denied, have you reapplied?	☐	☐	☐	☐	☐	☐				
Social Security (Family)	☐	☐	☐	☐	☐	☐				
If denied, have you reapplied?	☐	☐	☐	☐	☐	☐				
(2) Workers' Compensation	☐	☐	☐	☐	☐	☐				
(3) State Disability Insurance	☐	☐	☐	☐	☐	☐				
(4) Retirement or Pension	☐	☐	☐	☐	☐	☐				
(5) Salary Continuation	☐	☐	☐	☐	☐	☐				
(6) Unemployment	☐	☐	☐	☐	☐	☐				
(7) Government Retirement	☐	☐	☐	☐	☐	☐				
(8) Union	☐	☐	☐	☐	☐	☐				
(9) Other, e.g. Mortgage or Credit Protection	☐	☐	☐	☐	☐	☐				

Important: All information should be for your normal work week immediately before your injury or sickness.

6. Occupation (or Occupations) Title _____

7. **Employer**

a) Name (If self-employed, state business name) _____
b) Address _____
c) Telephone No. _____
d) Name of immediate supervisor _____ May we contact this person? ☐ Yes ☐ No

8. **Business**

a) Do you have ownership interest in this business? ☐ Yes ☐ No
If yes, what is the percentage of ownership at onset of injury or sickness? _____%
b) Does any family member have any ownership interest in this business? ☐ Yes ☐ No
If yes, please give name, relationship and percentage of ownership interest of each family member.

Name **Relationship** **% Ownership Interest**

_____
_____
_____

c) Type of Business Entity: ☐ C Corporation ☐ Sub S Corporation ☐ Partnership ☐ Sole Proprietor ☐ Other _____

d) Type of Business:
(i) product(s) produced _____
(ii) service(s) produced _____

e) Do you have any ownership interest or work activities in any other business(es) and/or for any other employer? ☐ Yes ☐ No
If Yes, please provide details

_____
_____
_____

9. Are you or your business(es) currently involved in or contemplating filing for bankruptcy? ☐ Yes ☐ No

10. a) Average number of hours worked each week: _____
    b) Usual daily hours: from _____ ☐ a.m. ☐ p.m. to _____ ☐ a.m. ☐ p.m.
    c) Days of the week worked: ☐ Mon ☐ Tues ☐ Weds ☐ Thurs ☐ Fri ☐ Sat ☐ Sun

11. Gross earned income prior to injury or sickness (before taxes, after business expenses) $ _____ /per month

12. a) Number of people you employ _____
    b) Number of independent contractors you engage _____
    c) Number of people under your supervision _____

13. a) Years with current employer (or, if self-employed, years in current business) _____
    b) Years in this occupation _____

14. **Occupational Duties (list in order of importance)**

Duty	Description	Hours Per Week
a)		
b)		
c)		
d)		
e)		

15. **Instruments, Tools or Equipment normally used by you in your occupation**

Description	Purpose	Hours Per Week
a)		
b)		
c)		
d)		
e)		

16. **Travel**

Does your occupation (or occupations) normally require travel other than between residence and principal place of business? ☐ Yes ☐ No

If Yes, please describe usual frequency, mode of transportation and average trip distance.

_____
_____
_____

17. a) Is there a position description for your job? ☐ Yes ☐ No
    b) Do you receive periodic performance reviews of your work? ☐ Yes ☐ No
    c) Please attach all available position descriptions, performance reviews, resumes and curricula vitae.

18. Do you require a license to conduct your job? ☐ Yes ☐ No If Yes, please provide:
    a) Type of license(s) _____
    b) License and/or certificate number(s) and state(s) _____
    _____
    c) Are all of your licenses current and in good standing? ☐ Yes ☐ No
    d) Are there any complaints, actions, or investigations pending involving you? ☐ Yes ☐ No
    e) Have you ever been the subject of a work-related disciplinary action? ☐ Yes ☐ No
    f) If no to 18(c) or yes to (d) or (e), please provide detailed explanation.

_____
_____
_____

19. Dominant Hand: ☐ Right ☐ Left

20. Work Conditions/Responsibilities (check all that apply)
    ☐ Works Alone ☐ Works on a Team ☐ Works Around Others ☐ Works at Home ☐ Contact with Public
    ☐ Any Protective Equipment? _____

21. **Requirements of your occupation (Check one or more of the following, which apply and best describe the demands of your occupation).**

In terms of an 8-hour work day, I am required to:				
Check Here for all that apply	Occasionally 1/4 – 1 1/2 hrs.	Frequently 1 1/2 - 5 hrs.	Constantly 5 - 8 hrs.	I cannot currently perform this task due to disability
☐ Reach	☐	☐	☐	☐
☐ Twist Neck	☐	☐	☐	☐
☐ Twist Body	☐	☐	☐	☐
☐ Walk	☐	☐	☐	☐
☐ Stand	☐	☐	☐	☐
☐ Sit	☐	☐	☐	☐
☐ Kneel	☐	☐	☐	☐
☐ Squat	☐	☐	☐	☐
☐ Crawl	☐	☐	☐	☐
☐ Drive	☐	☐	☐	☐
☐ Climb Stairs	☐	☐	☐	☐
☐ Climb Ladder	☐	☐	☐	☐
☐ Climb Other (Explain)	☐	☐	☐	☐
☐ Manipulate Objects With Left Hand	☐	☐	☐	☐
☐ Manipulate Objects With Right Hand	☐	☐	☐	☐
☐ Manipulate Objects With Both Hands	☐	☐	☐	☐
☐ Fine Finger Dexterity	☐	☐	☐	☐
☐ Enter Data/Keystroke	☐	☐	☐	☐
☐ Use Foot Pedals	☐	☐	☐	☐
☐ Speak – Express or Exchange Ideas Orally	☐	☐	☐	☐
☐ Hear – Recognize Sounds	☐	☐	☐	☐
☐ Use Sight-Near Vision	☐	☐	☐	☐
☐ Use Sight-Far Vision	☐	☐	☐	☐
☐ Perform Complex Problem Solving	☐	☐	☐	☐
☐ Interact With People/Clients	☐	☐	☐	☐
☐ Perform Written/Oral Communication	☐	☐	☐	☐
☐ Other (Explain)	☐	☐	☐	☐
☐ Lift	☐	☐	☐	☐
If Required, How Much Weight? _____ lbs. Frequently; _____ lbs. Maximum				
☐ Carry	☐	☐	☐	☐
If Required, How Much Weight? _____ lbs. Frequently; _____ lbs. Maximum				
☐ Push/Pull With Arms	☐	☐	☐	☐
If Required, How Much Weight? _____ lbs. Frequently; _____ lbs. Maximum				
☐ Push/Pull With Legs	☐	☐	☐	☐
If Required, How Much Weight? _____ lbs. Frequently; _____ lbs. Maximum				

22. **Previous Work History**

	Employer	Occupation Title	Duties/Responsibilities	From	To
a)					
b)					
c)					

23. Identify all work activities performed since disability began (include all profit and not for profit activities).

_____

_____

24. Education/Training (check all that apply)
☐ GED ☐ High School Diploma ☐ Trade School Certificate ☐ College (undergraduate degree)
☐ College (advanced degree) ☐ Currently Enrolled
If currently enrolled, please provide name, address of school or college and dates of enrollment.

25. Professional Insurance (i.e., Malpractice, Errors and Omissions, General Liability, etc.) - include carrier name(s), address(es) and policy number(s).

I declare that all answers, statements and information made or given by me, or at my direction, in connection with this claim are and have been complete and true. I further understand Berkshire Life Insurance Company of America or its representative(s) may request from time to time any documents which I have in my possession, supporting this statement, and I hereby agree to furnish them upon request.

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, may be committing a fraudulent insurance act, which is a crime and subject to criminal prosecution, substantial civil penalty and the stated value of the claim for each such violation.

Date

Signature of Insured

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ATTENDING PHYSICIAN'S STATEMENT

For Assistance, Call Toll Free 1-888-275-7473

Patient's Name and Address	File No.	Date of Birth	Social Security No.

History

(a) Date of first visit: (b) Date of most recent visit: (c) Date and time of next visit:
(d) List all dates of service for this condition:

(e) Did you advise the patient to stop working altogether? ☐ Yes ☐ No **If No**, did you advise the patient to reduce work activities? ☐ Yes ☐ No **If Yes to either**, please state when and why:

(f) Is the patient still under your care? ☐ Yes ☐ No
(g) Are you related to the patient by blood or marriage, or are you a member of the patient's household? ☐ Yes ☐ No
(h) Are you the patient's business or professional partner or employer, or a person who has a financial affiliation or business interest with the patient? ☐ Yes ☐ No

Medical Condition

(a) Current Diagnosis(es): If Pregnancy EDC _____
ICDA/DSM IV Code(s) _____

(b) Objective Findings:

(c) Subjective Symptoms:

Limitations and Restrictions

(a) Restrictions (Identify the risk associated with specific activities):

(b) Limitations (What are your patient's specific functional deficits?):

(c) If functional deficits are asserted, what evidence supports these deficits?
Subjective: Objective:

(d) Have you completed disability forms on behalf of the patient for other insurance carriers? ☐ Yes ☐ No
If Yes, please provide name and address of company(ies):

(e) Is the patient competent to endorse checks and direct the use and proceeds thereof? ☐ Yes ☐ No

(f) Remarks:

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, may be committing a fraudulent insurance act, which is a crime and subject to criminal prosecution, substantial civil penalty and the stated value of the claim for each such violation.

Physician's Name (please print)	Specialty(ies)	Telephone No. ( )
Address – Street, City or Town, State or Province, Zip Code		
Signature	Date	
What is a convenient time and/or day for our claim specialist or consulting physician to call you?		

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

BERKSHIRE LIFE INSURANCE COMPANY OF AMERICA
Home Office: 700 South Street, Pittsfield, MA 01201
Berkshire Life Insurance Company of America is a wholly owned stock subsidiary of
The Guardian Life Insurance Company of America, New York, NY

Authorization for Direct Deposit of Disability Benefit Payments

To set up a new claimant direct deposit authorization or make a change to an existing direct deposit authorization for receiving disability payments, please review and complete this form carefully to include the following information:

1. Check the appropriate box for either checking or savings account.
2. **For checking account, attach a voided blank check.**
3. **For savings account, attach a copy of the account statement or deposit slip that shows the bank's routing number and the claimant's account number.**
4. For Joint Account Holder(s), if any, read and sign the Joint Account Holder Agreement below.
5. Return the completed and signed authorization and attachment to:

   Claims Management Services
   Berkshire Life Insurance Company of America
   700 South Street
   Pittsfield MA 01201

I want my disability benefits paid by direct deposit to my bank account as indicated below. ☐ Yes ☐ No

I want to change my current account information as indicated below. ☐ Yes ☐ No

File Number _____

Policy Number(s) _____

Claimant Name _____

Claimant E-mail Address _____

Bank Name and Address _____

Account Type ☐ Checking Account **Attach voided blank check** ☐ Savings Account **Attach copy of account statement or deposit slip**

Bank Routing Number (ABA#) _____

Bank Account Number _____

Important information:

1. Once the requested enrollment set up or change is received and processed, Claims Management Services will notify you of the transaction effective date.
2. You may receive the Explanation of Benefit Statement before direct deposit processing is complete.
3. If you are changing your account, you may receive paper checks while the change is being processed.
4. Closing your account before Claims Management Services is notified will delay receipt of benefit payments.

I authorize Berkshire Life Insurance Company of America to initiate credit entries for my disability benefit payments and to initiate, if necessary, debit entries and adjustments for any credit entries made in error to my account indicated above in the bank named above and/or debit the same to such account.

I authorize Berkshire Life Insurance Company of America to transmit my Explanation of Benefits Statements to me through a secure internet server to my e-mail address.

This authority will remain in full force until (a) Berkshire Life Insurance Company of America receives written notification from the claimant of its change in such manner that the company and the bank can reasonably act on it or, (b) disability benefits are no longer due and payable, whichever comes first.

_____ _____
Claimant Signature Date

Joint Account Holder Agreement
I understand and agree that any funds deposited after the date of death of the Claimant are to be immediately returned to Berkshire Life Insurance Company of America.

_____ _____
Joint Account Holder Signature Date